STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155770	A. BUILDING 00 B. WING	06/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAS OF GUERIN WOODS	1002 SISTER BARBARA WAY GEORGETOWN, IN47122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for Investigation of Complaint IN00090126. Complaint IN00090126 - Substantiated. Federal/State deficiencies related to the allegations are cited at F223, F225, and F226. Survey dates: 6/2 and 6/3/11 Facility number: 011509 Provider number: 155770 AIM number: 200909280 Survey team: Jennie Bartelt, RN Census bed type: SNF: 15 SNF/NF: 14 Total: 39 Census payor type: Medicare: 1 Medicaid: 10 Other: 28 Total: 39 Sample: 4 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Submission of this plan ofcorrection shall not constitutean admission by The Villas of Guerin Woods to the allegation contained in this survey report. The Villas of Guerin Woods specifically and generally denies that the survey allegations are indicative of the quality of nursing care and serviceprovided to the residents ofthis health care facility. This plan of correction issubmitted in accordance withthe requirements of the Stateand Federal law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0223 SS=D	Quality review 6/08/11 by Suzanne Williams, RN The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure residents were free from mental and verbal abuse for 3 of 4 residents reviewed related to allegations of abuse in a sample of 4. (Residents B, D, and E) Findings include: During interview on Initial Tour on 6/2/11 at 2:40 p.m., the Assistant Administrator indicated the facility had reported four allegations of abuse to the Indiana State Department of Health recently. The Assistant Administrator indicated two nurses and one aide had been "let go" very recently related to the problems, and a third nurse had been terminated at an earlier time. The Assistant Administrator	F0223	F223 Resident B- was interviewedby the Quality of Life Director on May 27, 2011, to determine if there had been any other instances of perceived abuse or neglect by care givers. No instances were identified. This Resident has notexperienced a weight loss andattends activities as prior to this incident. (Exhibit #1). Resident D-was interviewed by theQuality of Life Director on April 29, 2011 to determine if there had been any other instances of perceived abuse or neglect by care givers. No instances were identified.This resident has not experienced a weight loss and attends activitiesas prior to this incident (Exhibit #2). Resident E-was interviewedby the Quality of Life Director on April 29, 2011 to determineif there had been any other instances of perceived abuseor neglect by care givers. No instances were identified. This resident has not experienceda significant weight loss and attends activities as priorto this incident (Exhibit 3). All residents were interviewed bythe	07/03/2011

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	indicated that staff need to realize that "having a bad day" is not an excuse for what the facility considers abuse of a resident. The Assistant Administrator indicated one of the abuse situations happened when a CNA turned a resident into a bed rail, but the resident was caught by another aide so injury did not occur. The facility's policy entitled "Abuse Prevention Policy" was provided by the Administrator on 6/2/11 at 4:40 p.m. Review of the policy indicated definitions including, but not limited to, "Abuse: Mental - Includes, but is not limited to, humiliation, harassment, threats of punishment, or spiritual and psychosocial well-being....Abuse: Verbal - Refers to any use of oral, written, or gestured language that includes disparaging and derogatory terms to Elders or their families, or within their hearing distance, to describe Elders in a negative manner, regardless of their age, ability to comprehend, or		Quality of Life Director, startingon April 29, 2011 and completedon May 27, 2011. These questionswere related to all forms of abuseand neglect. No instances ofperceived abuse or neglect wereidentified (Exhibit 4). Staff members Certified Nurse Aid#2, Licensed Practical Nurse #3, and Licensed Practical Nurse #5, were respectfully terminated 5/2/11,5/21/11, 5/31/11. The Board ofNursing was notified by telephone onMay 2, 2011 and May 31, 2011related to findings by Directorof Nursing and Human Resources.Attorney General which was notified on June 17, 2011 (Exhibit #5). The Administrator and The Director of Nursing reviewed the Abuse and Neglect Policy and Procedure on April 29, 2011 (Exhibit #6). The Director of Nursing in-serviced the staff on the Abuse and Neglect Policy and Procedure including the requirements to report any suspected abuse or neglect immediately on April 28, 2011 and completed on April 30, 2011. This in-service was followed with a written post test to ensure competence in the knowledgeof abuse and neglect (Exhibit#7). The Director of Nursing will in-servicestaff quarterly for one year, thenannually thereafter ongoing(Exhibit #8). The Policy of educating all new employees prior to working at the Villas will continue. Effective 6/5/11,all	

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	disability. Use of vulgar language within the hearing distance of Elders...." Upon request, files related to allegations of abuse received by the facility were placed on the work table in Villa 2 and found on 6/2/11 at 5:55 p.m. Review of the files indicated the following related to care of Residents B, D, and E. 1. Review of the file related to Resident E, indicated in "Brief Description: The Director of Nursing was approached on 4/27/2011 at 1:00 p.m. by [name], Certified Nursing Aide [CNA #4], stating she wanted to meet with her....There was an allegation made of physical abuse related to transferring an Elder...." The document indicated the alleged perpetrator, CNA #2, was placed on suspension 4/27/11, pending investigation, and terminated on 5/2/11. A handwritten statement, signed by		applicants during the interviewprocess will be given a behavior test to ascertain any potential ofabusive or harsh behavior and willbe dismissed from the interview process accordingly (Exhibit #9). Any temporary staff being utilized has been and will be in-serviced on the**SPECIFIC** facilities Abuse and NeglectPolicy and Procedure of the Villas(Exhibit #10). The Quality of Life Director in-servicethe Resident Council on abuse and neglect on May 27, 2011 and March 21, 2011. The elders wereinstructed to tell any staff theyfelt comfortable speaking to if there were concerns and/or to ask to speak with the Director of Nursing or Administrator (Exhibit # 11). The Quality of Life Director will audit, through interview 15% of theelders randomly to identify any perceived instances of Abuse andNeglect weekly for 4 weeks, biweeklyfor two months, monthly for three months, then as recommendedby the Quality Assurance Committee. These Audits will be presented to theAdministrator on an going basis(Exhibit #12). The Administrator will bring theseaudits to the Quality Assurance Committee for any recommendationsfor further actions.	

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	CNA #4 on 4/29/11, indicated, "On 4/25/11, [name of CNA #2] and I were getting [name of Resident E] up and dressed for the day. When changing her nightshirt [name of CNA #2] was very rough and pulling on her arms. When rolling her over she did not wait for assistance from me or give Elder any warning what she was doing. I had pulled the bed away from the wall to be able to assist on the opposite side and caught [name of Resident E] before her head hit the railing. The rest of the day when [name of CNA #2] would approach [name of Resident E] would close her eyes and pretend to be asleep. [Name of CNA #2] did try to feed [name of Resident E] at breakfast but was loud and acting in a very forceful manner and [name of Resident E] would not open her eyes or mouth...." 2. Review of the file related to Resident D, indicated in "Brief Description: The Director of Nursing was approached on			

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	4/27/2011 at 1:00 p.m. by [name], Certified Nursing Aide [CNA #4], stating she wanted to meet with her....There was an allegation made of mental abuse related to a comment made about odor during elimination." The document indicated the alleged perpetrator, LPN #3, was placed on suspension 4/27/11, pending investigation, and terminated on 5/2/11. A handwritten statement, signed on 4/29/11, indicated, "On 4/25/11 [name of Resident D] had an incontinence of bowel issue. She was very upset with herself that she had to have help in cleaning up. I reassured her that it was no big deal. [Name of CNA #6] and I cleaned her up (shower) and got her settled in the living room after assuring her that no one but us knew what was going on. [Name of LPN #3] then walked in and said, 'My god! What is that smell?' all right beside [name of Resident D]. I came into the nurses station and whispered that [name of Resident			

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	D] had a bowel problem and I had not gotten everything cleaned up yet I went to help another Elder to the bathroom and when I came back [name of LPN #3] had walked into [name of Resident D's] room and said, 'No wonder! Nothing has been cleaned up! [Name of LPN #3] then went into [name of Resident D's] room and bathroom spraying air freshener and continued spraying outside of the room and all around [name of Resident D] who was sitting in one of the living room chairs. [Name of Resident D] was crying at this point and was afraid that everyone knew what had happened...." 3. Review of the file related to Resident B indicated in "Brief Description: At the monthly staff meeting Director of Nursing [DON] was talking to the staff about abuse and different types of abuse. The staff was being instructed on the importance of reporting any abuse to the Administrator and Director of Nursing. The DON was			

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	approached by [name], Certified Nurse Aide [CNA #6], stating that she had an abuse allegation against a nurse. [Name of CNA #6] stated that the nurse was [name of LPN #5], Licensed Practical Nurse, who was being verbally abusive to this elder. She stated that [name of LPN #5] would tell elder to 'shut up, knock it off and quit acting like a baby." The document indicated the alleged perpetrator, LPN #5, was suspended 5/25/11, pending investigation, and terminated on 5/31/11. A handwritten statement, signed and dated 5/26/11, by CNA #6 indicated related to verbal abuse of Resident B, "[Name of LPN #5] went in to [name of Resident B] [room number], yelled at her told her to shut up, knock it off, and quit acting like a baby. I told her to leave and I would do it...." The statement did not indicate the date of the verbal abuse. A handwritten statement, signed			

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	and dated 5/27/11, by CNA #10 indicated, "I have witnessed [name of LPN #5] being verbally rough with [name of Resident B] a few times. As in saying '[Name of Resident B] you need to stop your yelling it's unneeded and ridiculous' last time we worked together. Also I have heard her voicing her opinion about the elders from the office while in the kitchen." During interview on 6/3/11 at 12:15 p.m. related to reporting allegations of abuse, CNA #10 indicated he had had a class about abuse, and "now I know what they're looking for." This federal tag related to Complaint IN00090126. 3.1-27(a)(1) 3.1-27(b)			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to ensure staff reported allegations of abuse immediately to the	F0225	F 225 Residentf Bwas intferviewed by tfhe Qualitfy oft Lifte Directfor on May 27, 2011, tfo detfermine ift tfhere	07/03/2011

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Administrator for 3 of 4 residents reviewed related to allegations of abuse in a sample of 4. (Residents B, D, and E)

Findings include:

Upon request, files related to allegations of abuse received by the facility were placed on the work table in the facility's Villa 2 and found on 6/2/11 at 5:55 p.m. Review of the files indicated the following related to care of Residents B, D, and E.

1. Review of the file related to Resident E, indicated in "Brief Description: The Director of Nursing was approached on 4/27/2011 at 1:00 p.m. by [name], Certified Nursing Aide [CNA #4], stating she wanted to meet with her....There was an allegation made of physical abuse related to transferring an Elder...."

A handwritten statement, signed by CNA #4 on 4/29/11, indicated, "On

had been any otfher instfances oft perceived abuse or neglectf by caregivers. No instfances were identffted. This residentf has notf experienced a weightf loss and atfends actfvitfes as prior tfo tfhis incidentf(Exhibitf #1).

Residentf D was intferviewed by tfhe Qualitfy oft Lifte Directfor on April 29, 2011 tfo detfermine ift tfhere had been any otfher instfances oft perceived abuse or neglectf by care givers. No instfances were identffted This residentf has notf experienced a weightf loss and atfends actfvitfes as prior tfo tfhis incidentf(Exhibitf #2).

Residentf E was intferviewed by tfhe Qualitfy oft Lifte Directfor on April 29, 2011, tfo detfermine ift tfhere had been any otfher instfances oft perceived abuse or neglectf by care givers
No instfances were identffted This residentf has notf experienced a signiftcantf weightf loss and atfends actfvitfes as prior tfo tfhis incidentf (Exhibitf #3).

All residentfs were intferviewed by The Qualitfy oft Lifte Directfor stfartfng on
April 29, 2011 and completfed on May
27, 2011. These questfons were relatfed
tfo all ftorms oft abuse or neglect tfo instfances oft perceived abuse or

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	4/25/11, [name of CNA #2] were getting [name of Resident E] up and dressed for the day. When changing her nightshirt [name of CNA #2] was very rough and pulling on her arms. When rolling her over she did not wait for assistance from me or give Elder any warning what she was doing. I had pulled the bed away from the wall to be able to assist on the opposite side and caught [name of Resident E] before her head hit the railing. The rest of the day when [name of CNA #2] would approach [name of Resident E] would close her eyes and pretend to be asleep. [Name of CNA #2] did try to feed [name of Resident E] at breakfast but was loud and acting in a very forceful manner and [name of Resident E] would not open her eyes or mouth...." 2. Review of the file related to Resident D, indicated in "Brief Description: The Director of Nursing was approached on 4/27/2011 at 1:00 p.m. by [name],		neglectf were identffted(Exhibitf #4). Stfaft members Certffted Nurse Aid #2, Licensed Practfcal Nurse #3, and Licensed Practfcal Nurse #5, were respectfully tferminatfed on 5/2/11, 5/21/11, 5/31/11. The Board oft Nursing was notffted by tfelephone on May 2, 2011 and May 31, 2011 relatfed tfo ftndings by Directfor oft Nursing and Human Resources Atforney General which was notffted on June 17, 2011 (Exhibitf #5). The Administfratfor and tfhe Directfor oft Nursing reviewed tfhe Abuse and Neglectf Policy and Procedure on April 29, 2011 (Exhibitf #6). The Directfor oft Nursing in-serviced tfhe stfaft on tfhe Abuse and Neglectf Policy and Procedure including tfhe requirementfs tfo reportf any suspectfed abuse or neglectf immediatfely on April 28, 2011 and completfed on April 30, 2011. This in-service was ftollowed witfh a writfen postf tfestf tfo ensure competfence in knowledge oft abuse and neglectf (Exhibitf # 7). The Directfor oft Nursing will in-service stfaft quartferly ftor one yeatfhen annually	

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	Certified Nursing Aide [CNA #4], stating she wanted to meet with her....There was an allegation made of mental abuse related to a comment made about odor during elimination." A handwritten statement, signed on 4/29/11, indicated, "On 4/25/11 [name of Resident D] had an incontinence of bowel issue. She was very upset with herself that she had to have help in cleaning up. I reassured her that it was no big deal. [Name of CNA #6] and I cleaned her up (shower) and got her settled in the living room after assuring her that no one but us knew what was going on. [Name of LPN #3] then walked in and said, 'My god! What is that smell?' all right beside [name of Resident D]. I came into the nurses station and whispered that [name of Resident D] had a bowel problem and I had not gotten everything cleaned up yet I went to help another Elder to the bathroom and when I came back [name of LPN #3] had walked into		tfhereafter ongoing(Exhibitf #8). The Policy oft educatfng all new employees prior tfo working atf tfhe Villas will contfnue. Eftectfvely 6/20/11, all applicantfs during tfhe intferview process will be given a behavior tfestf tfo ascertfain any potfentfal oft abusive or harsh behavior and will be dismissed ftrom tfhe intferview process accordingly (Exhibitf #9). Any tfemporary stfaft being utflized has been and will be in-serviced on tfhe **SPECIFIC** ftacilitfy Abuse and Neglectf Policy and Procedures oft tfhe Villas (Exhibitf #10). The Qualitfy oft Lifte Directfor-in-service tfhe Residentf Council on abuse and neglectf on May27, 2011 and March 21, 2011. The Elders were instfructfed tfo tfell stfaft tfhey fteltf comftortfable speaking tfo ift tfhere were concerns and/or tfo ask tfo speak tfo tfhe Directfor oft Nursing or Administfratfo(Exhibitf #11). The Qualitfy oft Lifte Directfor will auditf,tfhrough intferview15% oft tfhe elders randomly tfo identffty any perceived instfances oft abuse and	

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	[name of Resident D's] room and said, 'No wonder! Nothing has been cleaned up! [Name of LPN #3] then went into [name of Resident D's] room and bathroom spraying air freshener and continued spraying outside of the room and all around [name of Resident D] who was sitting in one of the living room chairs. [Name of Resident D] was crying at this point and was afraid that everyone knew what had happened...." During interview with on 6/2/11 at 2:05 p.m., the Assistant Administrator indicated CNA #4 was no longer on staff at the facility. The Assistant Administrator indicated she did not know why CNA #4 waited two days to report her concerns related to the abuse. The Assistant Administrator indicated the facility had been inservicing frequently about abuse prior the report, so staff had become more aware. 3. Review of the file related to		neglectf weekly fto4 weeks, biweekly ftor tfwo montfhs,tfhen as recommended by tfhe Qualitfy Assurance Commitfee. These auditfs will be presentfed tfo tfhe Administfratfor on an ongoing basis (Exhibitf #12). The Administfratfor will bring tfhese auditfs tfo tfhe Qualitfy Assurance Commitfee ftor any recommendatfons ftor fturtfher actfons Stfaft ftles were auditfed at100% on June 17, 2011 ftor license background Check by Jennifter Nally HR. All stfaft was ftound tfo have acceptfable license background check in place (Exhibitf #13).	

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	155770	A. BUILDING 00 B. WING	06/03/2011

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	Resident B indicated in "Brief Description: At the monthly staff meeting Director of Nursing [DON] was talking to the staff about abuse and different types of abuse. The staff was being instructed on the importance of reporting any abuse to the Administrator and Director of Nursing. The DON was approached by [name], Certified Nurse Aide [CNA #6], stating that she had an abuse allegation against a nurse. [Name of CNA #6] stated that the nurse was [name of LPN #5], Licensed Practical Nurse, who was being verbally abusive to this elder. She stated that [name of LPN #5] would tell elder to 'shut up, knock it off and quit acting like a baby." The document indicated the alleged perpetrator, LPN #5, was suspended 5/25/11, pending investigation, and terminated on 5/31/11. A handwritten statement, signed and dated 5/26/11, by CNA #6 indicated related to verbal abuse of Resident B, "[Name of LPN #5]			

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	went in to [name of Resident B] [room number], yelled at her told her to shut up, knock it off, and quit acting like a baby. I told her to leave and I would do it...." The statement did not indicate the date of the verbal abuse. A handwritten statement, signed and dated 5/27/11, by CNA #10 indicated, "I have witnessed [name of LPN #5] being verbally rough with [name of Resident B] a few times. As in saying '[Name of Resident B] you need to stop your yelling it's unneeded and ridiculous' last time we worked together. Also I have heard her voicing her opinion about the elders from the office while in the kitchen." During interview on 6/3/11 at 12:15 p.m. related to reporting allegations of abuse, CNA #10 indicated he had had a class about abuse, and "now I know what they're looking for." During interview on 6/3/11 at 2:05 p.m., the Assistant Administrator			

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	indicated that staff had been re-inserviced on what abuse is, and about reporting. She indicated one CNA, who was a new employee at the facility, told her at the other facility they "didn't consider it abuse like here." This federal tag related to Complaint IN00090126. 3.1-28(c)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure staff followed the facility's policy for reporting allegations of abuse immediately to the Administrator for 3 of 4 residents reviewed related to allegations of abuse in a sample of 4. (Residents B, D, and E) Findings include: The facility's policy entitled "Abuse	F0226	F226 Residentf B was intferviewed by tfhe Qualitfy oft Lifte Directfor on May 27, 2011, tfo detfermine ift tfhere had been any otfher instfances oft perceived abuse or neglectf by care givers. No instfances were identffted. This residentf has notf experienced a weightf loss and atfends actfvitfes as prior tfo tfhis incidentf(Exhibitf #1). Residentf Dwas intferviewed by tfhe Qualitfy oft Lifte Directfor on April 29, 2011 tfo detfermine ift tfhere had been any otfher instfances oft perceived abuse or neglectf by	07/03/2011

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	Prevention Policy" was provided by the Administrator on 6/2/11 at 4:40 p.m. Review of the policy indicated definitions including, but not limited to, "...11. Any Villas staff member who has knowledge of or reasonable cause to believe an Elder has been or is being abused...is obliged to make an immediate oral report to the Administrative Guide, the Director of Nursing or the Social Service Coordinator, if appropriate...." Upon request, files related to allegations of abuse received by the facility were placed on the work table in the facility's Villa 2 and found on 6/2/11 at 5:55 p.m. Review of the files indicated the following related to care of Residents B, D, and E. 1. Review of the file related to Resident E, indicated in "Brief Description: The Director of Nursing was approached on 4/27/2011 at 1:00 p.m. by [name], Certified Nursing Aide [CNA #4],		care givers. No instfances were identffted This residentf has notf experienced a weightf loss and atfends actfvitfes as prior tfo tfhis incident(Exhibitf #2). Residentf E was intferviewed By tfhe Qualitfy oft Lifte Directfor on April 29, 2011, tfo detfermine ift tfhere had been any otfher instfances oft perceived abuse or neglectf by care givers No instfances were identffted This residentf has notf experienced a signiftcantf weightf loss and atfends actfvitfes as prior tfo tfhis incidentf(Exhibitf #3). All residentf were intferviewed by The Qualitfy oft Lifte Directfor stfartfng on April 29, 2011 and completfed on May 27, 2011. These questfons were relatfed To all ftorms oft abuse and neglectf No instfances oft perceived abuse or neglectf were identffted(Exhibitf #4). Stfaft members Certffted Nurse Aid #2, Licensed Practfcal Nurse #3, and Licensed Practfcal Nurse #5, were respectfully tferminatfed on 5/2/11, 5/21/11. 5/31/11. The Board oft Nursing was notffted by tfelephone	

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	stating she wanted to meet with her....There was an allegation made of physical abuse related to transferring an Elder...." A handwritten statement, signed by CNA #4 on 4/29/11, indicated, "On 4/25/11, [name of CNA #2] were getting [name of Resident E] up and dressed for the day. When changing her nightshirt [name of CNA #2] was very rough and pulling on her arms. When rolling her over she did not wait for assistance from me or give Elder any warning what she was doing. I had pulled the bed away from the wall to be able to assist on the opposite side and caught [name of Resident E] before her head hit the railing. The rest of the day when [name of CNA #2] would approach [name of Resident E] would close her eyes and pretend to be asleep. [Name of CNA #2] did try to feed [name of Resident E] at breakfast but was loud and acting in a very forceful manner and [name of Resident E] would not open her		on May 2, 2011 and May 31, 2011 relatfed tfo ftndings by Directfor oft Nursing and Human Resources. Atforney General which was notffted on June 17, 2011 (Exhibitf #5). The Administfratfor and tfhe Directfor oft Nursing reviewed tfhe Abuse and Neglectf Policy and Procedures on April 29, 2011 (Exhibitf #6). The Directfor oft Nursing in-serviced tfhe stfaft on tfhe Abuse and Neglectf Policy and Procedure including tfhe requirementfs tfo reportf any suspectfed abuse or neglectf immediatfely on April 28, 2011 and completfed on April 30, 2011. This in-service was ftollowed witfh a writfen postf tfestf tfo ensure competfence in tfhe knowledge oft abuse and neglectf (Exhibitf #7) The Directfor oft Nursing will in-service stfaft quartferly ftor one yeatfhen annually tfhereafter ongoing (Exhibitf #8). The Policy oft educatfng all new employees prior tfo working atf tfhe Villas will contfnue. Eftectfve 6/20/11, all applicantfs during tfhe intferview process will be given a behavior tfestf tfo ascertfain any potfentfal oft	

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	eyes or mouth...." 2. Review of the file related to Resident D, indicated in "Brief Description: The Director of Nursing was approached on 4/27/2011 at 1:00 p.m. by [name], Certified Nursing Aide [CNA #4], stating she wanted to meet with her....There was an allegation made of mental abuse related to a comment made about odor during elimination." A handwritten statement, signed on 4/29/11, indicated, "On 4/25/11 [name of Resident D] had an incontinence of bowel issue. She was very upset with herself that she had to have help in cleaning up. I reassured her that it was no big deal. [Name of CNA #6] and I cleaned her up (shower) and got her settled in the living room after assuring her that no one but us knew what was going on. [Name of LPN #3] then walked in and said, 'My god! What is that smell?' all right beside [name of Resident D].		abusive or harsh behavior and will be dismissed ftrom tfhe intferview process accordingly (Exhibitf #9). Any tfemporary stfaft being utflized has been and will be in-serviced on tfhe **SPECIFIC** ftacilitfy Abuse and Neglectf Policy and Procedure oft tfhe Villas (Exhibitf #10). The Qualitfy oft Lifte Directfor in-service tfhe Residentf Council on abuse and neglectf on May 27, 2011, and March 21, 2011. The Elders were instfructfed tfo tfell stfaft tfhey fteltf comftortfable speaking tfo ift tfhere were concerns and/or tfo ask tfo speak tfo tfhe Directfor oft Nursing or Administfratfor (Exhibitf #11). The Qualitfy oft Lifte Directfor will Auditf, tfhrough intferview 15% OF The elders randomly tfo identffty any Perceived instfances oft abuses and neglectf weekly fto 4 weeks, biweekly ftor tfwo montfhs, tfhen as recommended by tfhe Qualitfy Assurance Commitfee. These auditfs will be presentfed tfo tfhe Administfratfor on an ongoing basis (Exhibitf #12).	

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	I came into the nurses station and whispered that [name of Resident D] had a bowel problem and I had not gotten everything cleaned up yet I went to help another Elder to the bathroom and when I came back [name of LPN #3] had walked into [name of Resident D's] room and said, 'No wonder! Nothing has been cleaned up! [Name of LPN #3] then went into [name of Resident D's] room and bathroom spraying air freshener and continued spraying outside of the room and all around [name of Resident D] who was sitting in one of the living room chairs. [Name of Resident D] was crying at this point and was afraid that everyone knew what had happened...." During interview with on 6/2/11 at 2:05 p.m., the Assistant Administrator indicated CNA #4 was no longer on staff at the facility. The Assistant Administrator indicated she did not know why CNA #4 waited two days to report her concerns related to the		The Administfratfor will bring tfhese auditfs tfo tfhe Qualitfy Assurance Commitfee ftor any recommendatfons ftor fturtfher actfon Stfaft ftles were auditfed at 100% on June 17, 2011 ftor license background Check by Jennifter Nally HR. All stfaft Was ftound tfo have acceptfable License background check in place (Exhibitf #13).	

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	abuse. The Assistant Administrator indicated the facility had been inservicing frequently about abuse prior the report, so staff had become more aware. 3. Review of the file related to Resident B indicated in "Brief Description: At the monthly staff meeting Director of Nursing [DON] was talking to the staff about abuse and different types of abuse. The staff was being instructed on the importance of reporting any abuse to the Administrator and Director of Nursing. The DON was approached by [name], Certified Nurse Aide [CNA #6], stating that she had an abuse allegation against a nurse. [Name of CNA #6] stated that the nurse was [name of LPN #5], Licensed Practical Nurse, who was being verbally abusive to this elder. She stated that [name of LPN #5] would tell elder to 'shut up, knock it off and quit acting like a baby." The document indicated the alleged perpetrator, LPN #5, was suspended 5/25/11, pending			

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	investigation, and terminated on 5/31/11. A handwritten statement, signed and dated 5/26/11, by CNA #6 indicated related to verbal abuse of Resident B, "[Name of LPN #5] went in to [name of Resident B] [room number], yelled at her told her to shut up, knock it off, and quit acting like a baby. I told her to leave and I would do it...." The statement did not indicate the date of the verbal abuse. A handwritten statement, signed and dated 5/27/11, by CNA #10 indicated, "I have witnessed [name of LPN #5] being verbally rough with [name of Resident B] a few times. As in saying '[Name of Resident B] you need to stop your yelling it's unneeded and ridiculous' last time we worked together. Also I have heard her voicing her opinion about the elders from the office while in the kitchen." During interview on 6/3/11 at 12:15			

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	p.m. related to reporting allegations of abuse, CNA #10 indicated he had had a class about abuse, and "now I know what they're looking for." During interview on 6/3/11 at 2:05 p.m., the Assistant Administrator indicated that staff had been re-inserviced on what abuse is, and about reporting immediately. She indicated one CNA, who was a new employee at the facility, told her at the other facility they "didn't consider it abuse like here." This federal tag related to Complaint IN00090126. 3.1-28(a)			